Chapter Two

Expanding the Scope of Federal Retirement, Health, and Education Activities

Vigorous debates among policymakers during the past year have focused on retirement income, health insurance, and education. The current limitations of federal programs in those areas and their rapidly escalating costs over the coming decades have prompted calls for policy actions. At the same time, the strong economy and growing budget surpluses that are projected over the next 10 years may provide expanded resources for new policy initiatives. The challenge facing policymakers is to balance the needs and opportunities for expansions in the short term with the consequences of those actions in the longer term.

Social Security and Medicare, which provide retirement income and finance the cost of health care for millions of elderly and disabled people, have been criticized on a number of grounds. Those programs, which will account for nearly $670 billion in federal spending this year, will grow dramatically as the baby-boom generation becomes eligible for benefits. Yet many elderly people have low income, and many do not have insurance coverage for prescription drugs. The Congress could restructure Social Security to increase the income of the elderly and broaden Medicare benefits. But such actions could exacerbate the long-term financing problems faced by those programs.

Although Medicare provides nearly universal coverage to the elderly population, millions of people under age 65 do not have health insurance. Various approaches to reducing that number have been proposed, including expanding federal programs, providing more generous tax preferences to pay for health insurance, and imposing stricter requirements on insurers and employers to induce them to cover more people. To significantly reduce the number of people without health insurance, however, such initiatives would probably require very large government expenditures or impose similarly large costs on the private sector.

The nation's future prosperity and its ability to pay for expanded federal programs over the long term depend in part on the effectiveness of its education system. State and local governments have traditionally been responsible for setting education standards and financing education services, with only a limited federal role. Yet a number of proposals have been advanced at the federal level to improve education outcomes. Some options—such as promoting the use of vouchers for public school students to attend private schools or requiring states that receive federal funds to undertake mandatory testing of their students—would not require large amounts of federal aid. Other proposals—including expanding the availability of preschool education, improving the effectiveness of elementary schools by reducing class size, or promoting greater investment in higher education—would require significant increases in spending. Despite uncertainty about the effectiveness of alternative policies, the importance of the issues is clear.

The discussion in this chapter is intended to provide a broad perspective on the nature of the pol-

icy problems, the scope of current federal programs, and the major approaches that have been proposed to expand federal funding or regulatory activity. Because the number of specific options that have been proposed is large, the chapter does not reflect a comprehensive set of proposals. Also, the inclusion or exclusion of a particular proposal does not imply its endorsement or rejection by the Congressional Budget Office (CBO).

Social Security

This year, the Social Security program will pay about $430 billion in benefits to about 45 million retired and disabled workers, their families, and their survivors. Nearly all workers and their employers now pay Social Security payroll taxes, and most people over age 65 (as well as many younger people) receive monthly benefits from the program.

Social Security is, by far, the federal government's largest program, playing a critical role in supporting the standard of living of its many beneficiaries. In recent years, people age 65 or older have received about 40 percent of their cash income from Social Security. Elderly people whose cash income is relatively low have been particularly reliant on Social Security. Families that have at least one member collecting Social Security benefits and that are in the lowest income quintile of elderly families have received almost 90 percent of their income from Social Security, compared with only 25 percent for those in the highest income quintile.

The Social Security Budget Story in Brief

Spending for Social Security has been growing at roughly the same pace as the overall economy in recent years and will continue to do so throughout the next decade. The share of the economy devoted to Social Security has been between 4 percent and 5 percent of gross domestic product (GDP) for the past quarter of a century and is expected to remain below 5 percent until 2015, according to the Social Security Administration.[1] Meanwhile, revenues from Social Security payroll taxes have increased rapidly as the economy has expanded. CBO projects that Social Security revenues will exceed program outlays by between $150 billion and $330 billion in each of the next 10 years.[2]

Once large numbers of the baby-boom generation begin receiving benefits, however, spending on Social Security (as well as on other programs for the elderly) will consume an increasing share of national income.[3] The Social Security program's trustees project that under the current benefit structure, total spending will rise to 6.6 percent of GDP in 2030.

The expected increase in Social Security spending as a share of GDP results from the aging of the population born during the 1946-1964 baby boom. As that cohort retires and becomes eligible for Social Security benefits (starting in 2008), the ratio of beneficiaries to workers is expected to surge. By 2030, there will be 47 beneficiaries per 100 workers covered by Social Security, compared with only 29 today, according to estimates from the Social Security Administration. The number of beneficiaries is expected to increase somewhat faster than the number of workers thereafter, as life spans continue to lengthen.[4]

1. *2000 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors and Disability Insurance Trust Funds* (March 30, 2000), p. 189, and tables available at www.ssa.gov, based on the trustees' intermediate assumptions.

2. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2002-2011* (January 2001), p. 19. More than 85 percent of the revenues credited to the Social Security trust funds are from payroll taxes levied on workers and their employers. Most of the rest is from interest received on trust fund balances and from a portion of the income taxes paid by Social Security beneficiaries whose adjusted gross income is above a specified amount.

3. Congressional Budget Office, *The Long-Term Budget Outlook* (October 2000).

4. *2000 Annual Report*, pp. 63 and 122. The intermediate assumptions in the report are that in 2030, the life expectancy of men who reach age 65 will be 17.5 years and that of women will be 20.4 years. In 2000, the life expectancy of men age 65 was 15.9 years, and that of women was 19.2 years. In 1940, soon after the Social Security program began, the life expectancies of men and women at age 65 were only 11.9 years and 13.4 years, respectively. ("Life expectancy," as used here, is the average number of years of life remaining for a person if that person experienced the death rates by age observed in, or assumed for, the selected year.)

Much attention has been focused on the outlook for the Social Security trust funds. Last year, Social Security tax revenues, together with interest and other intragovernmental payments, exceeded expenditures by about $150 billion, bringing total Social Security trust fund balances to over $1 trillion. Projections show those balances rising steadily over the next two decades, peaking at $6 trillion at the end of 2024 and then diminishing until the balances are exhausted in 2037. Once the funds are exhausted, the taxes collected for the Social Security program will equal only about 72 percent of the benefits owed.

But the size of trust fund balances bears no relationship to Social Security's obligations or to the country's ability to fund benefits. Once Social Security benefits begin to outstrip payroll tax collections, the federal government eventually will need to reduce Social Security benefits or spending on other federal programs, borrow, or raise taxes—regardless of the size of the trust funds. To fulfill the nation's promises to Social Security beneficiaries, the government must acquire resources from existing production when benefits are due. The ability to pay those future benefits and to fulfill other commitments will depend on the total financial resources of the economy, not on the balances in the trust funds. Actions taken now to boost capital accumulation, enhance productivity, and increase work effort could help build a larger economy in the future, which in turn would expand the capacity to fund future Social Security benefits, other federal commitments, and other claims of the elderly on the economy.

Proposals for Increasing Retirement Income

Despite the large amount spent on Social Security benefits, many elderly people still have low income. In the most recent year for which data are available, 1.0 million elderly men (6.9 percent of men age 65 or older) and 2.2 million elderly women (11.8 percent) had income below the poverty threshold.[5] Many others have income slightly above the poverty line. As the number of elderly people increases, the number with low income (but not necessarily the percentage) is likely to rise as well.

The Congress could take several approaches in the short run to improve the lives of the elderly by increasing their income, particularly those with low income, although that need not be the only goal of federal policies. To help raise the income of the elderly, the government could:

- Provide them with more income from Social Security or other public programs once they were no longer working;
- Encourage current workers to save more for their retirement by contributing to pensions, individual retirement accounts (IRAs), or other types of retirement plans; and
- Encourage people to work longer.

Numerous proposals in each of those areas have been made in recent years.

Increase Benefits. The first approach would be to target additional federal resources toward low-income elderly people. The Social Security program already does so by using a progressive benefit formula through which retired workers with a history of low wages receive benefits that replace a higher percentage of their preretirement earnings than the percentage replaced for other retired workers. The program also bases benefits for widows on the benefits for which their husbands had qualified, if that provides them with higher benefits than they would receive on the basis of their own past earnings. Both of those features could be strengthened, or new provisions could be enacted to specifically focus on beneficiaries with low family income. If those provisions were successful, some of the additional Social Security expenditures could be offset by reductions in outlays for Supplemental Security Income (SSI) and other means-tested programs.

For example, the "special minimum benefit" provisions in the current Social Security program could be revamped to increase benefits for people who worked many years at low wages. Fewer than

5. Bureau of the Census, *Poverty in the United States: 1999*, Current Population Reports, Series P60-210 (September 2000), Table 2. Poverty rates are particularly high for elderly women who are widowed or divorced, or who never married, and for the small group of elderly people who do not receive Social Security benefits.

200,000 people receive Social Security benefits under the current rules for special minimum benefits, and the average benefit they receive is below the poverty line.[6] Some Social Security reform plans call for a new provision that would raise the minimum benefit above the poverty line for retirees who worked most of their adult life at low wages.

But modifying the Social Security system to strengthen its role in providing adequate income to retired workers is difficult to do in a way that would ensure that most of the additional benefits went to low-income beneficiaries. This is because eligibility for Social Security benefits has never been based on need. As long as means-testing is eschewed, it is hard to focus additional Social Security benefits specifically on people who are in low-income families. For example, some people who receive low Social Security benefits have pensions and other sources of retirement income or have a spouse who has high benefits. Likewise, although a widow has a much higher likelihood of being poor than does the average elderly person, a policy that focused on improving the benefits of widows could also help those with higher income as well and could miss the majority of the low-income elderly.

An alternative method of helping low-income elderly people would be to increase both the number who receive SSI and the amount of their monthly benefit. This year, that means-tested program will provide over 6 million recipients with about $28 billion in federal benefits. (In addition, most states supplement the federal benefits.) About one-third of those recipients are age 65 or older; the others will qualify on the basis of their disabilities. Increasing maximum monthly SSI benefits would raise the income of current recipients and could bring other low-income elderly and disabled people into the program. (The maximum monthly benefit for an individual with no other income in 2001 is $530; for a couple, it is $796.) One way of helping some low-income elderly people who are not participating in the SSI program would be to reduce the requirements for becoming eligible for SSI, perhaps by allowing participants to have more assets. (The current resource limit is $2,000 for an individual and $3,000 for a couple.) Increasing benefits or expanding eligibility could, of course, substantially add to SSI program costs, especially if more people participated in the program.

Increase Savings. Another approach to increasing the income of the elderly would be to subsidize or otherwise encourage people to save more for their old age. That approach could increase the resources available to future retired workers and their families, but it would not help people who had already retired.

The federal government encourages workers to save for their retirement, largely through various tax incentives. For example, workers can receive favorable tax treatment for earnings that they and their employers put directly into qualified retirement plans, such as the commonly used 401(k) plans. They can also receive favorable tax treatment for money they invest in IRAs.[7]

Additional incentives could be provided by broadening the eligibility for existing plans, increasing the amount that workers can contribute, or developing new types of plans. For example, the Clinton Administration's proposal to establish retirement savings accounts would have provided eligible workers with matching contributions to encourage them to put money into a retirement plan. Several of the proposals for partial privatization of the Social Security program (discussed below) would also encourage or require workers to put money into investment accounts that they could not withdraw from before age 62.

A key issue in assessing any proposal of this sort is whether federal spending (directly or through reduced revenues) would actually increase overall saving or merely substitute for saving that would have occurred without the proposal. The majority of workers already save something for their retirement through pension plans, IRAs, and other investments. If the federal government subsidized workers to put aside money in a specific type of plan, they might put less into other accounts. Proposals that focus the subsidy on workers whose income is relatively low

6. Social Security Administration, *Annual Statistical Supplement, 2000*, Table 5.A7. In December 1999, 146,000 beneficiaries received an average monthly benefit of $556. Most of those beneficiaries were retired workers, whose average monthly benefit was $578. The annual poverty threshold for an elderly person living alone in 1999 was $7,990, or $666 a month.

7. Provisions in the tax code that include incentives to save are discussed in Chapter 6.

would suffer less from that problem because those workers are less likely to have pensions and other savings.

Increase Employment. Encouraging workers to delay retirement would also increase the income of the elderly. At age 62, most workers become eligible for Social Security benefits and must make two decisions:

- Should they continue to work and, if so, how much?
- Should they apply for Social Security benefits?

Within a year of becoming eligible for benefits, a majority of workers have stopped working (or substantially reduced their earnings) and a majority have filed for benefits. One consequence of those actions is that most of those workers subsequently have a smaller income than they would have had if they had postponed retirement. For example, workers who stop working and begin collecting benefits at age 62 this year will receive monthly Social Security benefits that are about 20 percent below the amount they would have received if they had delayed retirement and the receipt of benefits until age 65. Moreover, if they instead continued to work, fewer years of retirement would need to be financed out of whatever private savings they had already accumulated, and they might be able to save more for their retirement. Likewise, the size of any private pensions they had might increase somewhat. (The relevant Social Security rules are described in Box 3.)

Box 3.
Eligibility for Social Security and the Earnings Test

Workers can begin receiving Social Security retirement benefits as early as age 62, but the monthly benefits they receive will be lower than if they postpone filing. From age 62 to the full retirement age (also known as the "normal" retirement age), each year postponed adds about 7 percent or 8 percent to monthly benefits. Likewise, workers who delay collecting benefits beyond the full retirement age receive a credit for doing so. Each year delayed adds 6 percent to the monthly benefit of workers turning age 65 this year; the size of that credit is scheduled to gradually increase to 8 percent for subsequent birth cohorts.

Until last year, the full retirement age was 65 for everyone who was receiving benefits. Starting with workers born in 1938 (that is, workers who became eligible for retirement benefits in 2000), the full retirement age gradually increases from 65 to 67. For workers born in 1938, the full retirement age is 65 years and 2 months. For most practical purposes, that increase in the full retirement age simply reduces monthly benefits below what they would have been without the change; it does not alter the age of eligibility for benefits. For example, when the full retirement age was 65, the benefits of workers who began collecting them at age 62 were permanently reduced by 20 percent. When the full retirement age becomes 67, workers will still be eligible to collect benefits at age 62, but they will incur a 30 percent reduction. (Workers who began collecting retirement benefits last year at age 62 will receive about 1 percent less than they would have received had the full retirement age remained at 65.)

The rules requiring the withholding of Social Security benefits if beneficiaries have earnings in excess of a certain exempt amount—the "retirement earnings test"—are complicated and easily misunderstood. In 2001, the benefits of workers who are under the full retirement age are reduced by $1 for each $2 they earn above $10,680. (The earnings threshold automatically rises each year according to the annual increase in a national average wage index.) Workers whose benefits are reduced because their earnings exceed the threshold will subsequently receive higher monthly benefits—about 7 percent or 8 percent higher for each year in which benefits are entirely withheld because of the retirement earnings test. The increase in benefits in many cases will be even more than 8 percent because the additional earnings can raise the earnings base on which benefits are calculated. In short, even though the retirement earnings test is often portrayed as a tax on work, it is more accurately described as a means of deferring benefits until workers no longer have substantial earnings.

One way of encouraging people to work longer would be to eliminate Social Security's retirement earnings test so that people could begin to collect Social Security benefits at age 62 while they continued to work. Under current law, retirement benefits are reduced by $1 for each $2 that beneficiaries under the full retirement age earn above a specified threshold ($10,680 in 2001). Although those workers can later receive substantially higher monthly benefits as a consequence of that reduction, some people apparently are not aware of that and treat it as a simple benefit reduction. As a result, they either stop working before they would have in the absence of the retirement earnings test or, at least, keep their earnings below the threshold.

Until last year, a separate earnings test applied to workers ages 65 through 69. The Senior Citizens Freedom to Work Act of 2000, signed into law last April, repealed the earnings test for beneficiaries at the program's full retirement age but left in place the test for younger beneficiaries. As the full retirement age increases from 65 to 67 over the next two decades, the size of the group subject to the remaining earnings test will greatly expand.

Eliminating the retirement earnings test at age 62 would be quite costly initially because it would encourage workers who were already eligible for Social Security benefits to claim them. But the effect on Social Security spending would be small in the long run, according to the Social Security Administration's Office of the Actuary, because the earlier receipt of benefits would result in lower future monthly benefits.[8]

Proponents of eliminating the earnings test contend that it is unfair and counterproductive to penalize people who want to work. Workers ages 62 through 64 who are otherwise eligible for Social Security benefits may think they are facing a 50 percent tax on their wages if they earn more than the threshold amount. That tax rate is in addition to the payroll taxes and income taxes they already must pay. Although those workers may be mistaken, proponents of abolishing the earnings test argue that some people are working less to avoid any reduction in their Social Security benefits.

Opponents argue that the main effect of eliminating the earnings test would be to provide Social Security benefits to workers who already have a higher income than do many Social Security beneficiaries. The only people who would receive higher Social Security benefits if the earnings test was eliminated would be workers who earned above the threshold amounts. For example, 63-year-old workers who had earnings above the threshold this year and were otherwise eligible for the average Social Security benefit for workers their age would need to have a total income (earnings plus benefits) of almost $20,000 before their benefits would be reduced.[9] Another drawback of eliminating the earnings test is that workers who decided to claim benefits while still working would receive lower benefits after they stopped working than they would have received if they delayed filing for them. Thus, encouraging people to claim benefits at an earlier age could subsequently increase the number of elderly retired workers and their survivors who have low income.[10]

An alternative approach to increasing the income of the elderly is to raise the earliest eligibility age for Social Security retirement benefits. Several proposals for slowing the growth in Social Security spending include provisions that would gradually raise the earliest eligibility age from 62 to 65 and then link subsequent increases to changes in life expectancy. Such proposals would make people below the new eligibility age worse off by delaying their eligibility but would help ensure that they had higher income later. Unlike proposals to eliminate the retirement earnings test, this approach would initially

8. The Social Security Administration's Office of the Actuary estimates that eliminating the earnings test for workers age 62 or older would worsen the 75-year actuarial balance by a small amount. See the memorandum from Stephen C. Goss, Deputy Chief Actuary, to Harry C. Ballantyne, Chief Actuary, "Long-Range OASDI Financial Effects of Eliminating the OASDI Retirement Earnings Test," September 13, 1999.

9. In December 1999, the average monthly benefit paid to retired workers age 63 was $713 (see Social Security Administration, *Annual Statistical Supplement*, Table 5.A1). Including the subsequent cost-of-living adjustments they would have received, the annual amount of those benefits would now exceed $9,000. Thus, workers receiving average benefits and facing the $10,680 threshold could have a total income of almost $20,000 without any reduction in their benefits.

10. See Michael A. Anzick and David A. Weaver, "The Impact of Repealing the Retirement Earnings Test on Rates of Poverty," *Social Security Bulletin*, vol. 63, no. 2 (2000), pp. 3-11.

reduce Social Security spending because workers would need to wait longer to become eligible for benefits. In the long run, however, raising the earliest eligibility age without making other changes in the program probably would have little impact on Social Security spending because the workers would ultimately become eligible for higher benefits.

Proponents argue that the federal government should no longer be helping people retire at age 62, for several reasons. First, with the coming shift in the age distribution of the population, it makes little sense to give up the productive capacity and revenues that would result from more people working longer. Second, as life spans have increased and the average job has become less physically demanding, most people can work longer. Third, by enabling workers to trade lower future Social Security benefits for early access to benefits, the current rules for early retirement contribute to the higher poverty rates experienced by people who live to a very old age.

Opponents of raising the earliest eligibility age contend that it would be especially harmful to people who have little or no choice about when they stop working and who have few resources other than Social Security.[11] Those opponents argue that many low-earning workers are in physically demanding or unpleasant jobs and that by age 62, if not earlier, they have worked long enough.[12] Moreover, by that age, opportunities for those workers are not very plentiful if they lose their job, particularly if the labor market is weak. Another argument made by opponents is that raising the earliest eligibility age would be unfair to workers with a below-average life expectancy, especially if they left no survivors who were eligible for benefits.

11. See Congressional Budget Office, *Raising the Earliest Eligibility Age for Social Security Benefits*, CBO Paper (January 1999), for an analysis of the characteristics, circumstances, and financial resources of men and women who claimed Social Security retirement benefits at age 62 or 63 in the early 1990s. That paper found that the majority of those retired workers had pensions and other sources of income sufficient to keep them well above the poverty line even if they had not received Social Security. But a sizable minority of them had non-Social Security income below the poverty threshold and might well have had serious difficulty finding a job.

12. If the eligibility age was raised, more workers would probably apply for benefits under Social Security's Disability Insurance program instead. If they were successful, that program would incur additional costs.

Long-Term Reform

Both the Congress and the Administration are interested in addressing the problem of funding Social Security over the long term in a timely fashion. But policymakers sharply disagree about how to do so.

Benefit Reductions and Revenue Increases. Slowing the growth in spending for Social Security would be one way of reducing future budgetary pressures. Previous CBO reports have reviewed a wide range of options for doing that. For example, the formula used to calculate benefits for newly eligible beneficiaries could be altered to reduce their initial benefits; the age at which full benefits became available could be increased; or the cost-of-living adjustments beneficiaries receive could be reduced.[13]

Each option for slowing the growth in benefits, by itself, would leave some beneficiaries worse off than they would be if they received the benefits scheduled under current law and the benefits were paid for in some other way. If the changes were made in a way that preserved the benefits of those with the lowest benefits, then larger reductions would need to be made in the benefits received by other retired workers. That is, the benefit structure would need to be made more progressive.

Benefit reductions might be avoided by increasing Social Security taxes or other federal revenues. The Social Security program's trustees project that the gap between spending and program revenues in 2037 will be about 4.7 percent of taxable payroll. Thus, an increase in the combined payroll tax on workers and their employers from 12.4 percent to 17.1 percent at that time would be an alternative way of dealing with the shortfall.[14]

13. See Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options* (May 1998), Chapter 3. In addition, estimates of the budgetary savings for the 2002-2011 period for three specific ways of reducing benefits are presented later in this volume (see options 650-01, 650-02, and 650-03).

14. See *2000 Annual Report*, p. 171, and tables available at www.ssa.gov, based on the trustees' intermediate assumptions. The trustees project that the gap will remain below 5.0 percent of taxable payroll until 2055 and then will gradually increase to 6.2 percent by 2075.

Privatization. Numerous proposals have been made to pair a reduction in the Social Security program with the establishment of mandatory individual investment accounts that are owned and directed by workers themselves. Such proposals, often referred to as privatization, would give workers control over how their money was invested. Most privatization plans have at least these four elements:

- Reduce Social Security benefits below the amounts specified under current law;
- Require (or at least give a strong financial incentive to) workers to put a certain percentage of their earnings into individual investment accounts;
- Allow workers generally to decide for themselves how their accounts are invested; and
- Prohibit withdrawal of money from those accounts until workers reach a certain age.

Privatization proposals raise a number of issues concerning their potential consequences for the economy and for the income of workers and their families after the workers retire, become disabled, or die. Proponents of plans to replace all or part of future Social Security benefits with income from mandatory defined contributions contend that doing so would increase national income and enable workers to receive much higher returns on their investments than they could get by putting their money into the Social Security system. Opponents argue that those claims are exaggerated and that even partial privatization could subject workers, particularly low-wage workers, to unnecessary financial risk.

Although mandatory accounts would not resolve the projected shortfall between revenues earmarked for Social Security and program costs, they would provide an alternate source of income for former workers and their families if Social Security benefits were scaled back. Replacing part of Social Security with individual accounts would shift some financial risk, now borne collectively, onto the workers themselves, but at the same time it would offer workers the potential to increase their income in retirement. Some privatization proposals, however, provide a government guarantee if the returns on the investments are not as high as expected. Such proposals could increase the government's financial risk.

Medicare

The second-largest entitlement program after Social Security, Medicare provides health insurance coverage to people who are aged or disabled. It comprises two separate programs—Hospital Insurance (HI) authorized under Part A, and Supplementary Medical Insurance (SMI) authorized under Part B. The HI program pays for inpatient hospital care, some stays in skilled nursing facilities, some home health care, and hospice services. The SMI program pays for services from physicians, medical suppliers, and outpatient care facilities as well as for some home health care.

In 2000, the federal government spent about $220 billion to finance the health care of 39 million beneficiaries—60 percent of that cost was for the HI program and 40 percent for the SMI program. The HI program is financed entirely by a portion of the Social Security payroll tax levied on current workers and their employers. The SMI program is financed partly from monthly premiums paid by enrollees and partly from general revenues, which currently cover about 75 percent of costs.

Medicare spending has grown dramatically since the program began more than three decades ago, and that growth has been of increasing concern to policymakers. Between 1975 and 1997, Medicare spending grew faster than the economy, rising from 1.1 percent of gross domestic product to 2.6 percent.

Following years of rapid growth, however, spending for Medicare has slowed considerably in the past few years. Indeed, spending was actually lower in fiscal year 1999 than in 1998, though growth resumed in 2000, with spending up by 3.9 percent. Likely reasons for the temporary slowdown include the cost-reducing provisions of the Balanced Budget Act of 1997 (BBA) and the reactions of providers to enhanced federal efforts to combat billing errors and fraud.

The improved fiscal outlook for both Medicare and the overall budget has led to a greater focus on proposals to expand Medicare benefits, particularly to add coverage for outpatient prescription drugs and to limit total out-of-pocket expenses for beneficiaries. Medicare beneficiaries often incur substantial costs for prescription drugs, for which many of them—about a third—have no insurance protection. Moreover, unlike typical private insurance plans, Medicare does not cap beneficiaries' cost-sharing liabilities, leaving them without "stop-loss" protection against high costs even for services that the program covers.

In 1999, the Bipartisan Commission on the Future of Medicare considered a number of ways to address those two deficiencies. Subsequently, some members of the commission introduced a bill (S. 1895) in the 106th Congress based on one of the approaches they considered. That bill would have added a high option to Medicare, with both drug coverage and stop-loss protection for currently covered services. Other proposals would have added only a drug benefit: the Clinton Administration's proposal would have offered prescription drug coverage through Medicare, and a House-passed bill (H.R. 4680) would have subsidized drug coverage offered by private insurers.

Policymakers have raised concerns, though, that proposals to expand Medicare benefits could exacerbate the program's long-term financing problem. The leading edge of the baby-boom generation will become eligible for Medicare in 2011, and program costs are certain to increase rapidly thereafter under current law. Demand for Medicare services will grow dramatically over the next few decades, while the number of people in the labor force will grow much more slowly. Between 2000 and 2030, for example, the number of Medicare beneficiaries will almost double, compared with an expected increase of about 13 percent in the number of workers contributing payroll taxes. For that reason, some fundamental reform of Medicare's financing will be necessary even if current benefits are unchanged. If benefits are expanded, then Medicare's fiscal requirements would be still higher.

Expanding Benefits

Compared with the typical health insurance plan offered by employers, Medicare's benefit package is limited in significant ways. The program covers most basic services—hospital stays, postacute care, physicians' services, and other outpatient care—but excludes other services generally considered important. Perhaps the most notable omission is coverage for outpatient prescription drugs, which have become a significant expense for many beneficiaries. In 1997, spending on prescription drugs accounted for over 10 percent of the cost of health services for Medicare beneficiaries. Almost half of that cost was paid for out of pocket rather than through some type of insurance coverage. In addition to lacking coverage for prescription drugs, Medicare beneficiaries also lack coverage for many preventive services available to privately insured people.

Beneficiaries are potentially liable for significant costs even for the services covered by Medicare. For example, beneficiaries must pay a deductible equal to $792 in 2001 for each inpatient hospital stay, and hospital stays of more than 60 days require a substantial copayment. Care in skilled nursing facilities is also subject to substantial copayments after the first 20 days. Most outpatient services are subject to a $100 annual deductible, after which the patient is responsible for 20 percent of covered expenses (plus any additional amount that the physician is allowed to charge).

In part because Medicare leaves beneficiaries at risk for very large out-of-pocket costs, most beneficiaries seek some kind of supplementary coverage through employment-sponsored retiree health plans, private medigap plans, health maintenance organizations (HMOs), or Medicaid (for those whose income and assets are low enough to qualify). But such a patchwork arrangement generates a number of problems. First, it leaves unprotected a group of people (about 10 percent of beneficiaries) who do not qualify for Medicaid or coverage under a retiree health plan and who cannot afford an individual insurance supplement. Second, the coverage available from private supplements is eroding. The share of employers offering health coverage to their retirees has been declining in recent years, and the supplementary benefits offered by HMOs are also being scaled back in

response to lower rate increases from Medicare. Furthermore, because most medigap plans do not cover drugs, those that do so experience adverse selection (attracting enrollees who are more costly than average), resulting in such high premiums that few medigap enrollees purchase those plans. Third, the costs of administering insurance supplements are high because of the need to market to individuals and to coordinate benefit payments with Medicare.

Making Medicare's coverage more comprehensive would reduce or eliminate the need for private insurance supplements, but it would also mean that some of the costs now paid by beneficiaries, their employers, or state Medicaid agencies would be paid by Medicare. Expanding Medicare's benefits would also probably slow the shift of enrollment from Medicare's fee-for-service sector to risk-based Medicare+Choice (M+C) plans because those plans are currently one low-cost way in which enrollees can supplement Medicare's coverage. It might also accelerate the decline in employer-sponsored retiree health benefits.

Covering Prescription Drugs. Both the Clinton Administration and the House of Representatives developed proposals during the last session that would have added a prescription drug benefit to Medicare. The benefit would be offered under a new voluntary Part D of Medicare, in which beneficiaries would have a one-time option to enroll. Both proposals would provide additional subsidies to low-income participants in the drug benefit through the Medicaid program. Enrollees in M+C plans would get the drug benefit through those plans.

The proposals differ, however, in how the drug benefit would be administered in Medicare's fee-for-service sector. Under the Clinton Administration's proposal, the drug benefit would be administered by regional agencies that would not bear insurance risk. Under the House bill, the drug benefit would be provided by private plans that bore substantial risk but were partially protected by a reinsurance mechanism through Medicare. In areas where no private plan offered the benefit, the House bill would provide for a fallback Medicare offering. The two proposals also differ in the generosity of the benefit they would provide and in the amount of the premium subsidy (see Table 2).

The Clinton Administration's Proposal. As proposed in the President's budget submission in February 2000, a voluntary drug benefit under a new Part D of Medicare would begin in 2003. It would pay half of the cost of each enrollee's outpatient prescription drugs, up to a specified benefit cap. One-half of the benefit costs would be financed by enrollees' premiums, and the other half would come from general revenues. That initial proposal was modified in the June 2000 *Mid-Session Review* in two ways: the start of the benefit was moved up to 2002, and stop-loss protection for enrollees' cost-sharing expenses under the drug benefit was added. All of the costs of the stop-loss benefit were to be paid from general revenues. In 2003, the benefit cap would be $1,000 and the stop-loss amount would be $4,220. An enrollee with $1,000 in total drug costs would pay $500; one with $3,000 in total drug costs would pay $2,000; no enrollee would pay more than $4,220 in cost-sharing expenses in 2003. Premium expenses for Part D enrollees would be $24.40 a month, or $292.80 per year. That amount would cover 50 percent of the total cost for the basic drug benefit (without stop-loss protection) and about 33 percent of the cost for the full drug benefit.

Last year, CBO estimated that the Clinton Administration's midsession prescription drug proposal (as a stand-alone provision) would add about $13 billion to Medicare's net costs in 2002, its initial year of operation. That estimate excludes the cost of subsidies to low-income Medicare beneficiaries. Annual costs to Medicare of the drug proposal would increase to $54 billion by fiscal year 2010, and 10-year costs (2001-2010) would total $303 billion. The low-income subsidies under the proposal would add another $41 billion to the 10-year cost.[15]

Although Medicare enrollees who had high drug costs would be better protected with the addition of the stop-loss provision, those who spent enough on drugs to trigger that protection would no longer have to pay attention to drug prices. As a result, prices might increase for some drugs used heavily by Medicare enrollees—particularly drugs with no close substitutes. CBO estimated that after 10 years, the average price of drugs consumed by Medicare beneficia-

15. See CBO's Analysis of the Health Insurance Initiatives in the *Mid-Session Review* (July 18, 2000).

ries would be 8 percent higher under the Clinton Administration's proposal. Those higher prices would also increase drug costs under other federal programs—Medicaid, the Federal Employees Health Benefits program, and programs in the Department of Defense, the Department of Veterans Affairs, the Public Health Service, and the Coast Guard.

The House Proposal. Under the House bill (H.R. 4680) passed on June 28, 2000, a voluntary drug benefit under a new Part D of Medicare would begin in 2003. The bill would provide federal reinsurance payments to entities offering qualified drug coverage to Medicare beneficiaries. Eligible entities would include Medicare+Choice plans, retiree health plans, and other sponsors of prescription drug plans that offered either the specified standard coverage or a benefit that was at least actuarially equivalent. In 2003, the specified standard coverage would have a $250 deductible, 50 percent coinsurance up to a benefit cap of $1,050, and stop-loss protection at $6,000. An enrollee with $1,000 in total drug costs would pay $625; one with $3,000 in total drug costs would pay $1,950; no enrollee would pay more than $6,000 in cost-sharing expenses in 2003.

Estimated premium expenses for Part D enrollees would average $39.20 a month, or $470.40 per year, under the assumption that reinsurance payments made to plans would be reflected in lower premiums. On average, federal reinsurance payments would cover about 35 percent of plan expenses, so enrollees' premiums would cover about 65 percent of costs. The extent of the subsidy would vary across plans, however, depending on each plan's mix of low- and high-cost enrollees. In 2003, for example, plans with no enrollees whose drug costs exceeded $1,250 would receive no federal reinsurance payments, so enrollees' premiums would have to cover all of those plans' costs. Plans with some higher-cost enrollees would receive federal reinsurance payments designed to subsidize a larger share of costs for more costly enrollees.

Table 2.
Effect in 2010 of Selected Prescription Drug Proposals from the 106th Congress

	The Clinton Administration's *Mid-Session Review* Plan	The House Proposal (H.R. 4680)
Participation (As a Percentage of Medicare Enrollment)		
Participation Rate		
Participants in federally overseen benefit	87	75
Participants in federally subsidized employer-sponsored plans	6	n.a.
Total	94	75
Nonparticipation Rate		
Nonparticipants enrolled in Part B of Medicare	0	19
Other nonparticipants	6	6
Total	6	25
Costs (In billions of dollars)		
Net Costs for Medicare Drug Benefit	53.8	14.8
Net Federal Costs for Low-Income Subsidies	6.4	11.9

SOURCE: Congressional Budget Office (from March 2000 baseline).

NOTE: n.a. = not applicable.

Last year, CBO estimated that the drug benefit under the House bill (as a stand-alone provision, and excluding the costs of low-income subsidies) would add about $7 billion to Medicare's net costs in 2003, its initial year of operation. Annual costs to Medicare of the drug proposal would increase to about $15 billion by fiscal year 2010, and 10-year costs would total $86 billion.[16] The low-income subsidies provided under the bill would add another $60 billion to 10-year federal costs. CBO estimated that after 10 years, the average price of drugs consumed by Medicare beneficiaries would be about 2 percent higher under this bill.

Limiting Cost-Sharing Expenses. Medicare provides substantial protection for millions of beneficiaries against the cost of health care services. But the insurance protection Medicare now provides against high out-of-pocket costs could be significantly improved if cost-sharing expenses for currently covered services were limited to a maximum annual amount for each enrollee. Such stop-loss protection is typical in private insurance plans.

Neither the President's proposal nor the House bill would provide a stop-loss limit on enrollees' cost-sharing expenses for services currently covered under Medicare, but the bill developed by members of the Medicare Commission (S. 1895) would have limited such expenses, in addition to providing a drug benefit under a new high-option plan.[17] Adding stop-loss protection would increase Medicare's costs unless other aspects of the program were modified. For example, if enrollees' cost-sharing expenses were capped at $2,000 in 2002 with no other changes in current law, Medicare's net costs for the year would be nearly 7 percent higher. One option to limit costs would be to increase the cost-sharing requirements that Medicare beneficiaries would pay until they met an annual cap on those expenses. Combining stop-loss protection with the cost-sharing requirements described in Chapter 5 in option 570-12-A, for instance, would lower Medicare spending by about 1 percent in 2002. That alternative might be unpopular, though, because 70 percent of all beneficiaries would face at least a small increase in cost-sharing expenses, whereas only 10 percent would have their cost-sharing expenses fall because of the stop-loss protection.

Ensuring Access to Services. Since the BBA was enacted in 1997, Medicare spending has been at levels well below estimates made at that time. Health care providers and managed care plans have argued that those lower levels of spending will lead to access problems for beneficiaries, as some providers reduce services and managed care plans withdraw from certain geographic areas. In the Balanced Budget Refinement Act of 1999, the Congress restored about $17 billion in higher Medicare payments over five years, mainly to health care providers. In 2000, legislation increased payments to providers and managed care plans by another $36 billion over five years.

It is difficult to assess, however, whether Medicare rates paid to health care providers and managed care plans are adequate to provide access and quality services to beneficiaries. For example, the Medicare Payment Assessment Commission (MedPAC) and the Health Care Financing Administration reported that total hospital margins dropped from 6 percent in fiscal year 1997 to 3.9 percent in fiscal year 1998, but lower private payments accounted for three-quarters of the decline. Some of the sharpest declines in Medicare payments were in payments to home health agencies, which dropped 15 percent between 1997 and 1998 alone. Although a large number of home health agencies left Medicare between October 1997 and March 2000, surveys conducted by the General Accounting Office and the Office of Inspector General for the Department of Health and Human Services found that few beneficiaries had difficulty obtaining home health services.

Prior to passage of the Balanced Budget Act, there was widespread belief that Medicare's payment rates for Medicare+Choice plans were high—that is, they did not adequately reflect the relatively low-risk mix of enrollees the plans attracted. If true, Medicare tended to pay more for enrollees in M+C plans than it

16. See CBO's cost estimate for H.R. 4680, The Medicare Rx 2000 Act (June 28, 2000).

17. The original version of the Breaux-Frist proposal (S. 1895) provided a high-option plan offering both a drug benefit and stop-loss protection on cost-sharing expenses for currently covered services in a restructured Medicare that would have made the original fee-for-service plan compete on an equal basis with all other plans serving Medicare beneficiaries. A later version of the Breaux-Frist proposal (S. 2807) modified the drug benefit, eliminated the stop-loss protection for currently covered services, and continued the special status of the fee-for-service plan.

would have paid for those same enrollees in the fee-for-service sector. However, those relatively generous payment rates also enabled M+C plans to offer supplementary benefits to enrollees at little or no additional premium, helping to expand enrollment in that sector. The BBA reduced the rate of increase in payment rates for M+C plans, thereby reducing Medicare's costs but also causing plans to withdraw from some areas. For calendar year 2001, about 900,000 beneficiaries (about 14 percent of M+C enrollees) will be affected by such withdrawals. Plans that have not withdrawn are reducing the supplemental benefits they offer or charging higher premiums for them. Those responses by M+C plans might indicate that the payment rate changes in the BBA cut too deeply, but it is difficult to tell.[18] Therefore, it is not clear that higher rates will enhance access to care for beneficiaries. It is clear, however, that higher payments to plans and providers will increase long-term spending pressures on the Medicare program and reduce funding available for additional benefits, such as prescription drugs and preventive care.

Long-Term Reform

The large federal budget surpluses projected under current law have given policymakers confidence that the program will be adequately financed over the next decade. But over the long term, Medicare spending will grow much faster than the rest of the economy.

Medicare costs will increase dramatically after 2010, when the first of the baby boomers reach age 65. The number of beneficiaries will double over the next 30 years, and the growth rate of costs per beneficiary witnessed in the past may well accelerate with the aging of the Medicare population and continuing improvements in medical practice and technology. The Medicare trustees estimate that total Medicare spending as a share of GDP will nearly double over the next three decades, rising from 2.3 percent in 2000 to 4.4 percent in 2030.[19] CBO's long-term projections are even higher, predicting that Medicare spending will account for 5.6 percent of GDP by 2030.[20]

Although Medicare's financial condition has improved, policy actions must be taken if a balance between spending and revenues is to be maintained in the long term. Those actions might include options to increase premium revenues, change eligibility conditions to reduce the number of beneficiaries, reduce costs per beneficiary, or increase the payroll tax. Near-term examples for some of those approaches are set forth in Chapters 5 and 7. This section discusses more fundamental structural reform of the Medicare program.

The most direct way to reduce the spending pressure in Medicare would be to move from the current program, which covers a specific set of benefits and provides unlimited federal payments, to an approach that strictly limits the federal contribution to Medicare. For example, that contribution could be set to grow at some rate that could be sustained in the long run (such as the growth rate of the overall economy). If the cost of Medicare-covered services grew faster than the federal contribution, those additional costs would be borne by beneficiaries rather than by taxpayers. However, such a strict approach could sharply limit the financing available for health care and would transfer all the risk of excess growth in health care costs to beneficiaries. Unless other program changes were instituted that increased efficiency in the provision of Medicare services and thus slowed the growth in costs, many beneficiaries could ultimately have difficulty paying for basic Medicare services under such an approach.

An alternative approach would introduce mechanisms that would encourage more price competition among plans and providers while ensuring that growth in the federal contribution would at least match growth in premiums for qualified low-cost

18. The General Accounting Office believes its analysis indicates that the responses seen (withdrawal of home health agencies and M+C plans) are "adaptations to appropriately tightened payments following a period of unchecked growth." See General Accounting Office, *Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments*, GAO/T-HEHS-00-160 (July 19, 2000), p. 10.

19. *2000 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (April 20, 2000), Table III.B1—HI and SMI Incurred Disbursements as a Percent of Gross Domestic Product, p. 82.

20. Congressional Budget Office, *The Long-Term Budget Outlook* (October 2000), p. 17.

plans in each geographic area—a competitive defined-benefit approach. One variant of this approach would set the government's contribution equal to the premium charged by the lowest-cost plan in each area, where Medicare's traditional fee-for-service sector would compete for enrollment on the same basis as private plans. All qualified plans would submit the premiums at which they would be willing to offer the basic Medicare benefit package (or better). Beneficiaries would be able to enroll in at least one plan for which they would pay no more than a modest premium. Because beneficiaries would pay the full additional premium of a more expensive plan, they would have a financial incentive to seek out low-cost plans. Competition among plans for enrollment would help induce plans to provide adequate service at the lowest possible cost.

The Clinton Administration's *Mid-Session Review* proposal, the similar proposal developed in the Senate (S. 2087) in the last Congress, and the premium-support proposal developed by members of the Medicare Commission (S. 1895) are all weaker variants of the competitive defined-benefit approach. That is because they do not base the government's contribution on the cost of the lowest-cost plan in each area. Of those three proposals, S. 1895 would have the strongest cost-constraining effects because Medicare's fee-for-service sector would not have special status; that is, its costs would no longer serve as the benchmark for the government's contribution. Instead, the benchmark would be set by the enrollment-weighted average of premiums from all plans. The government's contribution would cover all premium costs for enrollees who chose a plan with a premium less than 85 percent of that average, and enrollees who chose more expensive plans would pay most or all of the excess premium costs.

By contrast, both the Clinton Administration's proposal and S. 2087 would maintain the special status of Medicare's original fee-for-service plan, and beneficiaries who chose to remain in the fee-for-service sector would continue to pay only the Part B premium. The government's contribution to the premiums of private plans would be linked to fee-for-service costs, as under current law, and beneficiaries would pay the additional premium costs of more expensive plans. Unlike under current law, beneficiaries who chose less expensive plans would share (with the government) in the savings. Thus, private plans could compete not only on benefits, as they do now, but also on premiums. However, because the government's contribution would be linked to costs in the fee-for-service sector rather than to the costs of low-cost plans in the area, the incentive for enrollees to seek out low-cost plans would be weaker than it could be under the competitive defined-benefit approach.

How effective a competitive approach would be in reducing growth in Medicare costs over the long term is uncertain. For one thing, the approach could not be implemented in areas where the Medicare population was too small to support multiple plans. In such areas, the traditional fee-for-service plan might be the only option, and reforms to make that plan more efficient would also be important. Even in areas populous enough to support competing plans, extensive regulatory oversight would probably be necessary to ensure that plans were competing fairly, that enrollees were well informed, and that access and quality of care were maintained. Finally, it is unclear whether managed competition causes only a one-time reduction in cost for each enrollee who moves from fee-for-service care to a managed care plan that is more efficient, or whether it can also slow cost growth once all beneficiaries who will switch to managed care have done so.

Health Insurance Coverage

Despite significant economic growth over the past decade and the lowest unemployment rates in 30 years, millions of people do not have health insurance coverage.[21] Policymakers are clearly concerned about the uninsured, and they have advanced various

21. The Census Bureau reports that about 42.6 million people lacked coverage in 1998. Analysts believe, however, that number may be overstated because of difficulties collecting that information through a survey. According to the Department of Health and Human Services, for example, "it is thought that the [Current Population Survey] over-counts the number of individuals who have been uninsured for an entire year, possibly because respondents answer based on current rather than previous coverage status. In addition, Medicaid coverage status is likely under-reported." See Assistant Secretary for Planning and Evaluation, *Understanding Estimates of the Uninsured: Putting the Differences in Context*, available at http://aspe.hhs.gov/health/reports/hiestimates.htm.

proposals to increase the number of people with insurance coverage.

The effectiveness of alternative policies for increasing the number of people with insurance depends in part on who the uninsured are, the length of time and the frequency with which they have no health insurance, and the reasons why they do not have coverage or lost prior coverage. A lack of health insurance coverage is primarily a problem of the nonelderly since Medicare covers people over the age of 65.

Although policymakers have focused considerable attention in recent years on the lack of insurance coverage among children, adults account for most of the uninsured population. Just under 14 percent of children lacked health insurance coverage in 1999—down from more than 15 percent in 1998—compared with about 19 percent of nonelderly adults.[22] The group most likely to be uninsured is young adults ages 18 to 24, who are less likely than others to obtain coverage through employment but are no more likely to be eligible for Medicaid or another public program.[23]

The percentage of adults without insurance varies according to employment and income characteristics. In general, workers who are self-employed or who work in small firms are less likely to have health insurance than workers in large firms. Small firms may have higher health insurance costs than large firms because of smaller risk pools and higher administrative and marketing costs, and their costs are likely to continue to rise. Health insurance status is also correlated with income. More than a third of the nonelderly population with income below the poverty threshold lacks health insurance, compared with 15 percent of those with income above the poverty line.

Some people who become uninsured find new coverage in a fairly short time, although others remain uninsured for extended periods. The Current Population Survey, which collects information annually on the health insurance status of people, does not provide information on the length of time a person is uninsured. However, studies using the Survey of Income and Program Participation suggest that most people are uninsured for less than a year. According to a Census Bureau analysis, about 29 percent of the U.S. population lacked health insurance for at least one month over a three-year period beginning in early 1993.[24] Half of all observed spells without health insurance lasted 5.3 months or less; only about 3.7 percent of the population had no coverage for the full three years.

The high and rising cost of health care has been an important factor contributing to the problem of the uninsured. Although premiums for employer-sponsored insurance grew relatively slowly during the mid-1990s, premium increases of 10 percent or more—substantially greater than general price inflation—are expected over the next few years. Rising costs may lead employers to reduce health benefits or drop coverage for their workers. And workers who face higher insurance premiums and less generous coverage may be less likely to accept that coverage.

Declining Medicaid enrollment during the mid-1990s also contributed to the number of uninsured. According to the Census Bureau, the percentage of nonelderly people covered by Medicaid fell from 12.7 percent in 1993 to 10.4 percent in 1998. Enrollment remained at 10.4 percent in 1999, perhaps due to expansions in Medicaid and the State Children's Health Insurance Program (SCHIP). The implementation of welfare reform contributed to the earlier decline in Medicaid enrollment. Some people who are no longer eligible for cash assistance do not apply for Medicaid, even though they still qualify for that program. Those people might obtain Medicaid coverage if they became ill and sought medical care.

The uninsured remain an important focus of concern among policymakers. People without health

22. Robert J. Mills, "Health Insurance Coverage," Current Population Reports, Series P60-211 (Bureau of the Census, September 2000).

23. Some young adults do not buy health insurance when it is offered by their employers. That decision may seem reasonable to them since they are generally in good health, have relatively low earnings, and may not want to spend money on insurance premiums. Such a decision may not be desirable from a broader perspective, however, since some of those people will incur unexpectedly high health costs due to accidents or the sudden onset of serious illness. If they are unable to pay the extraordinary costs of their own care, those costs will usually be absorbed by providers and passed on to other patients through higher charges for service.

24. Robert L. Bennefield, "Who Loses Coverage and for How Long?" Current Population Reports, Series P70-64 (Bureau of the Census, August 1998).

insurance are less likely to receive basic health care services than are those with insurance. A lack of insurance exacerbates other barriers to appropriate treatment. Low-income people, in particular, may not have access to physicians' offices near their home, may lack transportation, and may risk significant income loss (including loss of employment) if they take time off from work to seek treatment for themselves or their children. They may delay treatment until a condition becomes serious, which can result in costlier treatment than would otherwise have been necessary. Moreover, hospitals and physicians are often uncompensated for the care they provide to uninsured people. As health care markets become increasingly competitive, providers have more difficulty covering those costs. As a result, less health care may be available to the uninsured.

Overview of Policy Approaches

Three broad policy approaches could increase the number of people covered by health insurance:

- Expanding the scope and funding of government insurance programs (policymakers have recently focused on broadening eligibility for existing programs rather than creating a new government insurance program);
- Providing additional tax incentives for health insurance purchased in the private market or from an expanded government insurance program; and
- Regulating the private market to expand options for the purchase of lower-cost health insurance.

An alternative to increasing the number of people with insurance, not discussed here, would increase the direct provision of health services to people without coverage. That could be accomplished by expanding government funding for public health clinics and other providers.[25]

Various policies to increase the number of people with insurance coverage have been proposed in recent years. Many of those proposals combine expansions of federal health programs with broader tax incentives to help people purchase private insurance. In November 2000, for example, the Health Insurance Association of America, Families USA, and the American Hospital Association unveiled a plan that would:

- Expand Medicaid coverage to all people under 65 years of age with income up to 133 percent of the federal poverty level,
- Permit states to extend coverage under Medicaid or the State Children's Health Insurance Program to adults with income between 133 percent and 200 percent of the federal poverty level, and
- Offer businesses a nonrefundable tax credit to reduce the cost of health insurance for workers with income between 133 percent and 200 percent of the federal poverty level.

Such proposals recognize that there are many reasons why people do not have health insurance. A single policy approach may not be as effective as multiple approaches in extending coverage to the greatest number of uninsured people.

Proposals to expand either private or public insurance may increase the number of people with coverage, but they also provide an incentive for some insured people (or their employers) to drop their current coverage if it is less generous or more expensive than the new alternative. The displacement of private dollars by federal dollars, called crowding out, results in higher government costs and more participation in the new program than would be necessary if only people who could not get coverage participated. It is difficult to limit crowding out, however. Tough administrative restrictions, such as requiring that people be uninsured for some period of time before participating in a new federal program, could exclude many people. Moreover, federal subsidies provide additional benefit even to those who could have retained their existing coverage but instead opted for the new program.

25. Medicare and Medicaid also subsidize the provision of services to people without insurance through "disproportionate share payments" to hospitals that serve poor populations.

The extent of crowding out grows with the size of the subsidy provided by the proposal. But subsidies approaching the full cost of insurance might be necessary to induce most low-income people who were uninsured to purchase coverage or participate in a government program. Consequently, the cost of an ambitious proposal seeking to cover most of the uninsured is likely to be disproportionately higher than that of a policy with more modest goals.

The cost of proposals to expand coverage depends in part on other legislative and regulatory policies that affect the health insurance market. Recent debate over the cost-containing actions of managed care plans, for example, has raised legislative interest in imposing new mandates on health plans that would increase access to specialist care, payment for specific services, coverage of certain benefits, and portability of insurance. If such mandates were enacted, they would increase the cost of private insurance and ultimately could increase the number of people without private coverage. The cost of a proposal to expand health insurance coverage could rise as a result of such mandates if coverage is made more expensive and if that coverage is attractive to a larger group of people.

In designing a specific policy, attention should be paid to the financial incentives provided to participants in new or expanded government insurance programs or to purchasers of newly subsidized private insurance. Traditional fee-for-service insurance discourages the overuse of medical services by imposing cost-sharing requirements, including a deductible and coinsurance. But such requirements could also discourage the use of necessary services by low-income enrollees. The Medicaid program addresses this issue by requiring only nominal copayments for covered services. As an alternative to financial incentives that limit overuse, some Medicaid programs offer services through managed care organizations. Those plans directly limit the provision of services through physician gatekeepers and other utilization management tools. Tax-incentive or regulatory approaches to expanding private insurance coverage could require similar incentives to minimize unnecessary use of medical services.

Expanding Government Insurance Programs

Three government programs—Medicare, Medicaid, and the State Children's Health Insurance Program—offer health insurance to elderly, disabled, or low-income people. Some 60 million people are expected to participate in those programs in 2001 at an annual federal cost totaling about $370 billion.

Of the three programs, Medicare is the only one that is completely financed and run by the federal government. Both Medicaid and SCHIP are partnerships between the federal and state governments. The federal government sets basic standards for insuring populations and guidelines by which states will be reimbursed for a portion of the expenditures they incur for insuring individuals, but the administration of both Medicaid and SCHIP is left to the states. A federal initiative to expand coverage in those programs is thus not simply a matter of providing more federal funds. States' interest in taking advantage of new coverage options may depend on granting more flexibility in how they may use those dollars to better accommodate the needs and circumstances of their populations. Even then, some states may not expand their programs enough to make full use of the additional funds.

Making Medicaid Eligibility Broader and More Uniform. Medicaid is an entitlement program that provides medical assistance to low-income people who are aged, blind, disabled, or members of families with dependent children. It also covers certain other pregnant women and children. The program is funded jointly by the federal and state governments, with federal payments ranging from 50 percent to 83 percent of total expenditures. Outlays for Medicaid in 2001 are expected to be about $130 billion for the federal government and nearly $100 billion for the states. About a third of Medicaid spending is for long-term care services.

Medicaid is the principal source of health insurance for low-income people, but that coverage varies among states. Federal eligibility requirements are complex, and states have wide latitude to set their own eligibility standards above federally mandated levels. States must cover pregnant women and children under age 6 with family income below 133 per-

cent of the federal poverty level. By 2002, states are required to phase in coverage for all children under age 19 with family income below the poverty line. In addition, states may provide Medicaid coverage to certain women diagnosed with breast or cervical cancer who would not otherwise be eligible.

Beyond those requirements, states vary widely in the populations they cover under Medicaid. At their option, states may cover pregnant women and infants (under the age of one) whose family income is at or below 185 percent of the poverty threshold; about 30 states do so. Although some states have not covered all people whose income is below the poverty level, other states have chosen to enroll particular groups of people with income considerably above the poverty line, using options available under current law or through waivers granted by the Health Care Financing Administration. As noted earlier, there is no guarantee that states will expand their programs even if federal funding is increased and federal restrictions on the use of those funds are loosened, although some states surely would.

The number of low-income people who are covered by insurance could be increased, for example, by broadening federal eligibility requirements for Medicaid to make them more uniform among states for people facing similar economic circumstances. Options might include requiring all states to cover pregnant women and children with family income up to 185 percent of the poverty threshold or to cover all people up to some income level. Permitting or requiring states to cover groups that are not traditionally covered under Medicaid is another way to expand coverage. The likelihood of states' implementing any of these policy approaches would increase by enhancing the federal matching rate for newly covered populations.

Such policies would probably increase the number of people with insurance, but not all people targeted by each policy would enroll. Some people might wish to avoid the perceived stigma of enrolling in a welfare program. Others might delay enrolling in Medicaid until they needed services. Still others —who, before the passage of welfare reform in 1996, might have been automatically eligible for Medicaid as recipients of Aid to Families with Dependent Children—might not realize that they were eligible for the new benefit. Special outreach efforts would probably be required for the expansion of the program to be effective.

Other people (particularly those with higher income) who enrolled in an expanded Medicaid program would have had insurance even without that expansion. Some of them would have purchased individual coverage but would choose Medicaid because of its lower out-of-pocket costs, broader benefits, or both. Others would have had employment-based coverage. Some employees would refuse that coverage if they became eligible for Medicaid when the program expanded. Some employers would also have an incentive to drop health insurance if most of their workers could obtain coverage elsewhere, although that might leave some workers uninsured.

Broadening federal eligibility requirements for Medicaid would have a differential impact on states, depending on the generosity of their current programs. Less prosperous states tend to have relatively narrow eligibility rules, at least partly because they are less able to pay for large programs. Those states might argue that mandating broader national eligibility requirements would impose an unreasonable fiscal burden on them.

Expanding the Scope of SCHIP. The State Children's Health Insurance Program provides enhanced federal matching funds to assist states in covering low-income children. Federal payments range from 65 percent to 83 percent of program spending, depending on a state's average per capita income. States may use SCHIP funds to expand Medicaid, to develop or expand other insurance programs for children, or to provide services directly. In addition, states may subsidize the purchase of family coverage through employment-based insurance if that option costs less than covering only the children.

The Medicaid program, as an entitlement, serves all those who are eligible and enroll, regardless of the federal cost. Federal funding for SCHIP, however, is limited in total and at the state level. Federal outlays for SCHIP are expected to be about $3 billion in 2001. States are developing programs that may ultimately enroll an average of 2.5 million children annually. Given the size and focus of the current program, the extent to which proposals to broaden

SCHIP would reduce the total number of people without health insurance depends on both the amount of new federal funding and the additional flexibility extended to the states to design and implement programs.

In enacting SCHIP, the Congress recognized that states might have difficulty starting new programs quickly. Consequently, states were initially given three years to spend their budgetary allocations; the Secretary of Health and Human Services would redistribute unspent funds in the fourth year to states that had spent their allocation. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended to five years the time period in which states could spend a portion of their 1998 allotment. In addition, certain states may now use a greater portion of their SCHIP funds for outreach.

Some analysts have criticized SCHIP as too narrowly circumscribed to be effective in increasing the number of children with health insurance. Although states may now cover parents of eligible children by requesting a waiver from the Health Care Financing Administration, the authority to expand eligibility for SCHIP could be broadened and left solely to states' discretion. If states used that authority, more people would become insured through SCHIP, but some of them would have had group or individual coverage without the expansion. Some employers would discontinue their offer of insurance unless SCHIP subsidized that coverage.

Extending Medicare to Younger Ages. Unlike Medicaid and SCHIP, which do not offer insurance to all low-income people, Medicare provides nearly universal coverage to people age 65 or older and to many disabled individuals. In 2001, Medicare outlays will total almost $240 billion and will finance health services for 40 million people.

Options for expanding Medicare eligibility target older adults who are not yet 65. Those people have more difficulty obtaining insurance than do younger people, and their premiums are high because they use more health services. The Clinton Administration proposed allowing displaced workers ages 55 to 61 to purchase Medicare coverage. A separate proposal would allow certain people ages 62 to 64 to enroll voluntarily in Medicare.

The cost and effectiveness of such buy-in proposals depend on specific design features. The program for displaced workers would be narrowly targeted. Workers (and their spouses) would be eligible if they lost health insurance because of a job loss. Other eligibility requirements would include receiving employment-based health insurance for a period of time before enrolling in Medicare, being eligible for unemployment insurance, and exhausting coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). (COBRA requires employers to offer unsubsidized health insurance to workers (and family members) that continues after workers leave their job.) Premiums under a Medicare buy-in would be set at relatively high levels. Participants would, however, be able to claim up to 25 percent of their buy-in premiums as an income tax credit. CBO estimated last year that about 90,000 people would be enrolled in the program at any one time by 2010. Those most likely to enroll would be people whose medical expenditures were higher than average for their age. Premiums would not fully cover program costs, and net Medicare outlays would rise by about $200 million between 2002 (when the program would have begun) and 2010. Tax revenue forgone due to the tax credit would amount to $700 million over that period, and federal outlays for unemployment compensation would increase by about $100 million.

The proposed Medicare buy-in for people ages 62 to 64 is designed to attract greater enrollment. Enrollment would be limited to people who did not have employment-based insurance, Medicaid, or coverage through another government program. They would have to enroll as soon as they became eligible, such as when they turned age 62 or when they first lost employment-based coverage if they were already older than 62.

People buying in to Medicare under those circumstances would pay premiums that would approximately cover their expected cost to the program over their lifetime. The premiums would be paid in two parts. Before the age of 65, enrollees would pay premiums that reflected the average expected cost of benefits if everyone ages 62 to 64 participated in the

buy-in. However, as with the buy-in for displaced workers, the people most likely to enroll would have higher costs than average for their age. Thus, premiums before age 65 would not fully cover the program's costs during those years. To offset those costs, people who bought in to Medicare early would pay a premium surcharge (in addition to their regular Supplementary Medical Insurance premium) once they reached age 65. Up to 25 percent of premiums paid prior to age 65—but none of the premiums paid subsequently—could be claimed as an income tax credit.

Using those specifications, CBO estimated last year that the buy-in for people ages 62 to 64 would increase Medicare outlays by about $46.2 billion between 2002 (when the program would have begun) and 2010. Premiums would total slightly more than that, resulting in a small net savings for the program. Tax revenues would be reduced by about $7.7 billion because of the tax credit. About 650,000 people would participate in 2002, and about 1.3 million people by 2010.[26]

Many of the people who would buy in to Medicare before they were 65 would have been insured even without the program. Most of them would have purchased coverage in the individual market. But the buy-in would give some people who were working and covered by employment-based insurance an incentive to retire early. CBO assumed that an additional 1 percent of workers ages 62 to 64 would retire early and buy in to Medicare if that option became available.

A policy that encouraged early retirement even to that limited extent would exacerbate long-term budgetary pressures. A buy-in policy could, however, be part of a broader initiative to slow the growth of Medicare spending. As discussed below, the early buy-in could be coupled with a gradual delay beyond 65 in the age at which people become eligible for full Medicare benefits, comparable with the increase in Social Security's normal retirement age.[27] The modest program savings that would be realized over the next 10 years from such an approach would grow rapidly in later years as an increasing number of people were affected by the change.

Some employers would drop their health insurance for retirees because of the availability of a subsidized Medicare buy-in. The prevalence of employer-sponsored retiree coverage has been declining, and the buy-in proposal would accelerate that trend. Other policy proposals, such as adding a Medicare prescription drug benefit, could worsen that adverse consequence of a buy-in. Such a benefit would also likely be subsidized, making it attractive to some firms to drop private insurance that was more expensive or less generous to their retirees.

Providing Tax Incentives for the Purchase of Insurance

The tax system currently provides substantial subsidies for health-related expenses, including the purchase of health insurance. The federal government annually forgoes over $110 billion in tax revenues, according to some estimates, by excluding from income and payroll taxes the contributions that employers make for health benefits and by allowing deductions for certain other health expenses. Those tax expenditures have significantly lowered the net cost of health insurance premiums and other payments for health services for millions of people, primarily benefiting the more than 170 million people with employment-based insurance. Existing tax incentives might be restructured, or new ones added, to encourage additional people to purchase health insurance.

Subsidies Under the Current Tax Code. The largest health-related federal tax subsidy is the exclusion of employers' payments for health insurance and other health expenses from workers' taxable income. Other health expenses that enjoy favorable tax treatment include benefits paid through cafeteria plans and flexible spending accounts, as well as employers' contributions for long-term care insurance. According to one estimate, the income tax exclusion ac-

26. Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001* (April 2000), p. 48.

27. See option 570-19-B, Permit Early Buy-In to Medicare and Increase the Normal Age of Eligibility, in Chapter 5.

counted for over $65 billion in federal tax expenditures in 1998.[28] Employers' contributions for health benefits are also excluded from payroll taxes, accounting for about $30 billion in forgone federal revenues.

Self-employed taxpayers may deduct part of their health insurance payments from taxable income. That deduction is "above the line" and is available to people who use the standard deduction as well as to those who itemize. Under current law, a self-employed person may deduct 60 percent of health insurance costs this year. That deduction rises to 100 percent by 2003.

Taxpayers who itemize their deductions may also use the medical expense deduction, which is geared toward families who incur high medical expenses (relative to their income). That provision allows them to deduct unreimbursed medical expenses that exceed 7.5 percent of adjusted gross income. Medical expenses include health insurance payments paid by the taxpayers, out-of-pocket payments for medical care, and certain costs for transportation, lodging, and long-term care.

In addition, people who choose to purchase qualifying high-deductible health insurance and are not otherwise covered may establish tax-preferred medical savings accounts (MSAs). MSAs are personal savings accounts that can be used to pay deductibles, copayments, and other health expenses not covered by insurance. Consumer demand for MSAs has been weak, however. According to the General Accounting Office's evaluation of the MSA demonstration program authorized by the Health Insurance Portability and Accountability Act of 1996, only about 42,000 MSAs were opened as of the end of 1997.[29] Of that number, about 15,500 MSAs were opened by people who were previously uninsured. One explanation for the lukewarm response is the complexity of the health plan/MSA product that qualifies for the tax preference. That complexity has proven to be a barrier for both insurance agents and consumers. In addition, many people prefer insurance plans with a lower deductible than is permitted under the demonstration.

The tax system heavily favors health insurance purchased through employers over coverage purchased in the individual market. People without access to employment-based health insurance cannot take advantage of a substantial tax benefit, and they often face higher premiums than people who are covered through their job. Moreover, tax incentives in the current system are regressive. Since tax savings depend on the taxpayer's marginal rate, people in the highest tax brackets, who are most able to afford coverage, receive the largest subsidies. People who have low income and little or no income tax liability receive little or no subsidy if they buy health insurance.

The tax exclusion is an inefficient way to subsidize health benefits. Because the amount of employer-paid health insurance premiums that may be excluded from workers' taxable income is unlimited, that provision encourages employers to offer more insurance relative to cash compensation than they otherwise would. Excessive insurance also encourages covered workers to use more health services than they would if they were paying the full costs of those services. For that reason, some proposals would limit the amount of the tax exclusion while expanding other tax incentives.

Options for Expanding Tax Subsidies. Expanding tax subsidies for the purchase of health insurance could reduce the net cost of premiums, thus providing an incentive for more people to enroll in a health plan. The current structure of tax incentives could be extended to more people through the broader use of deductions, exclusions, or tax credits. However, simply extending those provisions to additional people would not address the inherent inefficiency of subsidies that rise in lockstep with health insurance premiums. That makes purchasers less sensitive to price increases and encourages the purchase of excessive insurance. Alternatively, the tax system could be restructured to expand insurance coverage more efficiently than at present.

People who do not have access to employment-based health insurance do not benefit from the tax exclusion and must pay the full cost of any coverage

28. John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, vol. 18, no. 2 (March/April 1999), p. 178.

29. General Accounting Office, "Medical Savings Accounts: Results from Surveys of Insurers," GAO/HEHS-99-34 (December 1998), p. 12.

they buy in the individual market. As a result, they are less likely to have health insurance than are people who can obtain coverage through an employer.

One option would allow those people to deduct their health insurance expenses from taxable income. For example, H.R. 2990, the patient protection legislation passed by the House last year but not signed into law, would establish an above-the-line deduction (not subject to the requirement that deductible expenses exceed 7.5 percent of adjusted gross income) for certain health and long-term care insurance costs. The deduction would be available to those who paid at least 50 percent of their health insurance costs. The provision would be phased in starting in 2002, and the full deduction would become available starting in 2007. The Joint Committee on Taxation (JCT) estimated that such a deduction would cost the federal government nearly $50 billion in lost revenues through 2010. The same legislation would also permit full deductibility of health insurance costs by self-employed individuals beginning in 2001 rather than 2003 under current law. That provision would cost about $2 billion in lost tax revenues through 2010 according to JCT's estimates.

An expanded tax deduction of this kind would be regressive—benefiting those with higher income more than those with lower income—and might provide the greater benefit for people who would have purchased insurance coverage anyway. This option would probably induce few uninsured people to purchase insurance because most of them have low or moderate income. According to JCT, only about 6 percent of the 13.1 million taxpayers who would claim the above-the-line deduction in 2007 under H.R. 2990 would otherwise be uninsured. The other 94 percent would have purchased insurance without the expanded deduction. In that year, the total cost of this provision would be about $7 billion, or about $4,250 for each newly insured person under the assumption that an average of two people would be covered under each policy. Although such a proposal would have limited effectiveness in increasing the number of people with health insurance coverage, it would eliminate the apparent inequity of providing tax subsidies to people who have employer-sponsored coverage.

Another option would offer a tax credit to people purchasing insurance in the individual or group market. That approach would be less regressive than expanding a tax deduction, but people with no income tax liability would not benefit unless the credit was refundable. A number of tax credit proposals were introduced in the 106th Congress. Those proposed credits were typically refundable and ranged from $500 to $1,200 for individual policies and $2,000 to $3,600 for family coverage.

The amount of a tax credit would have to be fairly large—approaching the full cost of the premium—to induce a large proportion of the uninsured population to buy insurance. Many uninsured people have low income and would not be able to pay much toward their health insurance. Some may be counting on the services of public hospitals and other publicly supported providers, which often write off the costs of care or require only modest payments from their patients. Moreover, many people who might be induced to buy insurance because of a tax subsidy would have access only to the individual market, whose premiums are generally higher than those in the group market. To make coverage more affordable, some tax credit proposals would permit uninsured people to buy in to government-sponsored insurance programs, including Medicaid, Medicare, or the Federal Employees Health Benefits program.

Other, more sweeping proposals would alter the current tax treatment of health insurance benefits in the context of a new tax credit. As discussed above, one approach would limit the amount of the tax exclusion, which would increase tax revenues and discourage the purchase of excessively generous insurance. For example, the maximum health insurance spending that could be excluded from taxable income could be limited to the cost of a health plan that provided coverage of basic services. The additional cost of more expensive insurance would then be unsubsidized. The additional tax revenues that would be collected could be used to finance a refundable tax credit. Another approach would replace all of the current tax preferences for employment-based coverage with a tax credit for everyone purchasing insurance. Such a credit could be used to purchase insurance as many people do now, through their employers. Other proposals would make the credit available only to people who buy insurance through the indi-

vidual market, effectively eliminating the role of employers. That might reduce the risk of having workers lose insurance coverage if they changed jobs.

Any proposal to expand tax incentives for the purchase of health insurance would have to deal with a host of technical issues that would determine the proposal's cost and effectiveness in increasing insurance coverage.[30] Some of those issues include:

- Defining the eligible group,
- Relating the subsidy to family income or some measure of need,
- Timing the receipt of the subsidy to coincide with the payment of premiums, and
- Defining and enforcing new regulatory standards for qualified insurance plans.

A tax subsidy could be targeted toward people who did not have access to employment-based coverage, or it could be made available to a broader group. Making a subsidy available to all who purchase health insurance might be the easiest policy to administer, but a substantial amount of federal aid would go to people who would have been insured anyway. Narrowing the focus to those who did not have access to employer-sponsored insurance might be more cost-effective, but it would be administratively more complex. Any coverage that might have been available to a person and possibly a spouse would have to be verified, possibly long after the fact. In addition, such an approach might encourage employers to drop their health plans. Requiring employers to continue to offer that coverage could be difficult to enforce.

Tax subsidies could readily be tied to a family's income. But low family income, by itself, might be a criterion that distributes those subsidies inefficiently. A more complete indicator would reflect both income and the level of health costs. The subsidy might also be adjusted to reflect variations in the average cost of health care in different geographic locations or other factors. Such adjustments might help ensure that people in high-cost areas could buy as much care as people in low-cost areas.

An often-voiced concern about tax subsidies is that they would provide cash to families only at the time of tax filing, not when the cash was needed to pay premiums throughout the year. The health insurance tax credit that was available during the early 1990s did not offer payment advances, for example, and participation was well below expectations. One way to implement payment advances would be to lower income tax withholding. But making such adjustments precisely could be difficult, and some people might face unexpectedly high tax bills the following year. In addition, some other method of making advances would be needed for people who were eligible for a tax subsidy but did not have earnings.

Standards would be needed to define how health insurance plans that qualify for a tax subsidy could operate. Such standards might define a minimum benefit package that all health plans would have to offer, limit cost-sharing requirements, and establish other regulations for the private insurance market. Those regulations might include rules for medical underwriting, requirements to make insurance coverage available and renewable, limits on the premiums that may be charged, and other issues. Such standards and regulations are typically intended to protect consumers by minimizing opportunities for selection by insurers. Insurers might compete for healthy, low-cost policyholders by offering less comprehensive, and less expensive, coverage that is unattractive to sicker consumers who expect to use more health care. Standards specifying a minimum benefits package would limit the ability of insurers to profit from that favorable selection. Such standards could lead insurers to offer broader benefits to both healthy and less-healthy consumers, but at higher costs than might have been the case without those standards.

Expanding Private Coverage Through Regulation

Expanding government health insurance programs or increasing the generosity of tax preferences for health insurance could require substantial new budgetary costs. Alternatively, regulation of the private insurance market could be modified with the intention of

30. For a more complete discussion of those issues, see Jack A. Meyer and others, *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2000).

increasing health insurance coverage. Regulatory approaches have the appeal of not requiring new government spending, but they generally would impose additional costs on employers and the insurance industry that would ultimately be paid by consumers.

Both the Congress and the states have passed legislation affecting the benefits, cost, and accessibility of private health insurance, but the states have primary responsibility for regulating insurance. All states have passed legislation mandating the inclusion of specified benefits in health plans, which may have increased the cost of insurance. Most states also require insurers to issue insurance to all groups who apply and to guarantee the renewal of that coverage, and states frequently regulate the premiums that may be charged for health insurance. In addition, some states have passed legislation creating health insurance purchasing cooperatives to facilitate insurance coverage for employees in small firms.

Federal regulatory initiatives have been intended to ensure more continuous coverage for people who are usually insured and to increase the number of lower-cost options available in the small-group market. Additional proposals might be considered to improve the availability and portability of insurance coverage and to reduce the cost consumers pay for that coverage.

Improving Insurance Availability and Portability. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addressed concerns that workers had become locked into their current employment because they risked losing insurance coverage for some period of time if they changed jobs. That act expanded COBRA protections for workers who leave their job. It also required insurers to make insurance available to people who had prior group or employer-sponsored coverage, and it guaranteed renewal of that coverage. The law limited the use of exclusions for preexisting conditions, which exempt the plan from paying for expenses related to a medical condition that already existed when the enrollee joined the plan.

The insurance mandates in HIPAA were intended to make group health insurance more available to workers and to make it easier for workers to change jobs by making that coverage more portable. But the law also imposed costs on insurers that would increase premiums somewhat—by about $500 million annually by 2001, according to CBO's estimates. The impact on insurance enrollment is uncertain: the increase in cost would tend to reduce coverage, but the loosening of insurers' restrictions would increase enrollment by some groups of people.

Additional initiatives might be considered to improve the continuity of private insurance coverage. Some options would extend the period of time over which COBRA coverage was available or broaden the availability of that protection. For example, firms that dropped their retiree health benefits might be required to offer their early retirees who were enrolled in the health plan extended COBRA coverage —perhaps until those retirees reached age 65 and became eligible for Medicare. Such a requirement could discourage employers from dropping their retiree health plans, but it could also discourage employers from offering coverage in the first place. Expanding COBRA coverage in that way would raise the cost of health insurance for workers, and fewer employees would enroll.

Making Small-Group Insurance More Affordable. Employees in small firms typically face higher health insurance costs than those in larger firms and are therefore less likely to have health coverage. Small firms typically face high premium costs because the risk associated with a small number of employees in the insurance pool is significant. In addition, the administrative cost of small-group policies tends to be high because there are fewer employees among whom to spread the cost. As a result, premiums in the small-group market are relatively high, discouraging firms with healthier employees from offering coverage. Moreover, small firms may face substantial increases in premiums if even one of their employees experiences high medical costs in a year. Large firms, in contrast, generally pay lower premiums because they can spread the risk of a high-cost employee over a much larger insurance pool.

Small firms lack purchasing power, limiting their ability to bargain for lower rates from providers and insurers. They have fewer employees to pay the fixed costs of a health plan, including marketing and enrollment, so their average administrative expenses are high. And small firms generally purchase cover-

age that is subject to state benefit mandates and premium taxes, both of which increase average premiums. Larger firms that self-insure are exempted from those state insurance regulations by the Employee Retirement Income Security Act.

Concerns about the affordability of insurance coverage in the small-group market have prompted recent proposals to establish association health plans (AHPs) and HealthMarts. Those new entities are intended to provide small firms and their employees with some of the premium-lowering cost advantages enjoyed by larger firms, including lower administrative costs and enhanced purchasing power. AHPs and HealthMarts would also enable small firms to avoid some regulations that generally increase their insurance costs.

AHPs could be sponsored by trade, industry, or professional associations and could offer a full range of health plans, including a self-insured plan, to their member firms. Both self-insured and fully insured plans (offered by a licensed insurer) would be exempt from state-mandated coverage of benefits. An AHP would offer its plans only to members of its sponsoring association and could price its premiums to reflect the expected health care costs of its association members rather than the costs of the small-group market as a whole.

HealthMarts would be nonprofit organizations that offered health insurance products to all small firms within an approved geographic service area. A HealthMart would have to make all of the plans it offered available to any small employer within its service area. Health plans offered through HealthMarts would be exempt from most state benefit mandates. Like AHPs, HealthMarts could offer premiums reflecting the expected health care costs of potential enrollees in small firms in its designated geographic service area rather than the entire small-group market in the state. Unlike AHPs, HealthMarts could offer only fully insured plans from insurance issuers licensed in the state.

Insurance offered through AHPs and HealthMarts could significantly lower premiums for some small firms compared with coverage offered in the traditional (fully regulated) small-group market. Some of those premium savings would result from exempting AHPs and HealthMarts from state-mandated coverage of benefits that may not be strongly demanded by employees of small firms. AHPs and HealthMarts would also attract firms with healthier-than-average employees, further lowering their own premiums (but modestly raising the average premium paid in the remainder of the small group market). Other savings might result from reduced administrative costs or increased market power through group purchasing. Those savings would most likely be modest, however.

The exemption from state-mandated benefits could foster the favorable selection of firms with healthier employees. AHPs and HealthMarts might design benefit packages that were relatively unattractive to firms whose employees had costly health care needs. Lower-priced plans with leaner benefits might appeal both to firms that offered no coverage to their employees and to firms with healthy employees that already offered insurance.

If firms with healthier-than-average employees switched from traditional coverage to AHPs and HealthMarts, premiums for some firms in the traditional market would rise. However, proposals generally include requirements that would limit the ability of AHPs and HealthMarts to attract healthier groups. AHPs would have to offer their plans to any small firm that qualified for membership in the sponsoring association. Similarly, HealthMarts would have to make their plans available to any small firm located in a HealthMart's designated geographic area. And both types of plans would be subject to limits on the premiums they could charge. Moreover, aggressive efforts by AHPs and HealthMarts to obtain favorable health risks would add to administrative costs, which could temper such efforts to attract healthier groups.

In a recent analysis, CBO estimated that introducing the new entities would increase the number of people insured through small firms by approximately 330,000.[31] Many more people—about 4.6 million—would be attracted to the new plans by their lower premiums, but most of those people would otherwise have been insured through the small-group market.

31. See Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*, CBO Paper (January 2000).

Some firms and workers in the traditional market would drop coverage because their premiums would increase, but most would continue their coverage and pay slightly higher premiums.

Education

The federal government historically has played a small role in funding the U.S. education system. While the Department of Education administers about 175 programs, federal funds represent only about 7 percent of the cost of public elementary and secondary education. State and local tax revenues provide most of the funding for public schools; parents of students in private schools pay most of those costs.

The same is true for other types of education. Most of the cost of preschool is paid by parents, with limited support from government sources for children in poor families. And although the federal government is providing about $23 billion in 2001 to help students pay for their postsecondary education through grants, loan subsidies, and tax benefits, family contributions and state subsidies have always been far more significant sources of funding for colleges and universities.

Nonetheless, the success of the education system is critical to the future of the nation, and there is no shortage of proposals at the federal level to improve education outcomes. The broad goals of those proposals are to promote equal opportunity; enhance the skills, productivity, and income of future workers; and provide greater assurance that children will become adults who can function effectively in society. Specific proposals might be more or less successful in achieving those goals.

Some of the proposals would require only small amounts of additional federal spending. One such option would require states, as a condition of receiving federal education aid, to use national tests to measure the educational performance of their children. Most states voluntarily participate in the National Assessment of Educational Progress, a program that assesses the performance of samples of fourth- and eighth-grade students in reading and math. That program allows comparisons of students' performance across states and subgroups of schools or students and comparisons over time. It also measures what children can do in comparison with what educators believe they ought to be able to do by certain ages.

However, comparisons of students' test scores across states may not provide useful information on the performance of their education systems. For example, it is not clear how much of a difference in test scores can be attributed to school systems' performance and how much is due to factors beyond the classroom. Parental support and a home environment that encourages learning may be more important than school in helping children gain those cognitive and behavioral skills that will help them succeed in school and beyond.

An alternative approach might be to require states to administer an annual assessment of their own design to all children in key grades. That would allow for assessment of the academic achievement of individual students over time and the performance of individual schools over time, which is not possible with the National Assessment of Educational Progress. While state-designed assessments do not allow comparisons among states, they can be linked to state curriculum standards and do allow parents and school administrators to track the progress of a student and the performance of a school in relation to those standards. In fact, states might be required to publish school report cards from those assessments in ways that are easy for parents to understand and use.

Another option would relax many of the rules governing the use of federal education funds by states and school districts, but at the same time make them accountable for producing positive results with those funds. Many existing federal education programs that aid states and school districts target specific populations of children or specify particular strategies for improving education. Combining funding for several of those programs into a single block grant that could be used for any of the purposes of the component programs would give states and school districts the flexibility to direct federal aid toward the schools' greatest needs. Requiring states to demonstrate progress (such as specified improvements in students' test scores) would hold them accountable

for their use of the federal funds. States that failed to meet their goals could lose a portion of future federal funds.

A fourth option would use existing federal education funds to provide vouchers to low-income students who attend underperforming public schools, enabling them to enroll in another public or private school of their choice (including charter schools). Under one such proposal, the average amount of federal Title I aid per student (about $1,500) would be made available to each student in a school that does not raise its educational performance to an adequate level within three years. The students would be able to attend another public school and use vouchers for tutoring or other educational resources, or they could use vouchers to help pay for tuition to attend a private school. Only a few school districts in the United States have experimented with voucher programs, and the evidence of their effectiveness in raising educational performance is mixed.

Many other proposals would require significant increases in federal spending. Prominent among education spending initiatives are these strategies:

- Help children become better prepared to learn when they enter school by expanding the availability of preschool programs, most notably Head Start;
- Improve the effectiveness of elementary and secondary schools by hiring more teachers and improving their training, as well as making improvements in facilities and other infrastructure; and
- Increase support for investment in education beyond high school by expanding federal student aid programs, especially Pell grants.

Expanding Preschool Education

Adequate preparation is a critical factor for success in school. Some analysts believe that the greatest return from additional spending in education could be obtained by investing in early childhood education.

Although universal public schooling is available starting at age 5, many younger children attend preschool programs. About 46 percent of 3-year-olds attend some type of center-based program, as do about 70 percent of 4-year-olds. Even with existing federal efforts focusing on low-income children, however, preschool attendance rates remain lower among children from lower-income families than among those from higher-income families. In 1999, the preschool enrollment rate for 3- and 4-year-olds from families with annual income below $20,000 was 52 percent, compared with a rate of 68 percent for children from families with income above $50,000.

Head Start is the primary federal preschool program serving poor children. It provides a comprehensive set of services, mostly to eligible 3- and 4-year-olds, that includes child development, education, health, nutrition, social, and other services. The program strives not only to improve the education outcomes of children but to achieve other goals as well, including improving health status and reducing aggressive and other antisocial behavior.

In 2000, the program enrolled an estimated 877,000 children, about 70 percent from families with annual income below $12,000. The average federal service grant per child was about $6,000, with funds going directly to the approximately 1,500 public and private nonprofit agencies that operated the Head Start centers. In general, local grant recipients must generate contributions from other sources valued at 25 percent of the federal service grant.

Federal funding for Head Start has grown rapidly in recent years, rising from about $1.2 billion for the 1989-1990 program year to about $6.2 billion for the 2001-2002 program year. Increases occurred with the rise in the number of 3- and 4-year-old participants, which nearly doubled, and with the introduction of the Early Head Start program. That program provides early intervention services to pregnant women and families with infants and toddlers.

The Effectiveness of Preschool Programs. Two mechanisms could explain how children's experiences at age 3 or 4 might improve their subsequent

education outcome.[32] Preschool might improve children's ability to think and reason as they enter school, enabling them to learn more in the early grades and keeping them "on track" toward high school graduation. It might also help increase their motivation to learn. The success children have in early grades could lead to higher expectations and added support from their parents and teachers, increasing their drive to succeed.

The effectiveness of preschool programs remains unclear, however. Most analysts agree that early childhood education programs in general can have positive short- and medium-term effects on participants' cognitive and social development, but there is less evidence about the longer-term effects of the programs. Although cognitive gains may fade, other effects—such as lower placement rates into special education and lower retention in grade—seem to persist.[33]

While analyses of small-scale "model" preschool programs find long-term reductions in crime, teenage childbearing, and use of social services, those effects may not pertain to Head Start. Head Start teachers are often less well trained than teachers in model programs. Likewise, most Head Start programs do not provide some of the services, such as in-home tutoring, that are usually part of the model programs. Although both types of programs generally show favorable effects on reducing the placement of students in special education programs and on reducing the retention of students in grade, the question of Head Start's effects on participants in the long term remains open. In 1997, the General Accounting Office concluded that the body of specific research on Head Start was inadequate for use in drawing conclusions about the impact of the national program.[34]

32. Deanna S. Gomby and others, "Long-Term Outcomes of Early Childhood Programs: Analysis and Recommendations," *The Future of Children: Long-Term Outcomes of Early Childhood Programs*, David and Lucile Packard Foundation, Los Altos, Calif., vol. 5, no. 3 (Winter 1995), p. 10.

33. Janet Currie, *Early Childhood Intervention Programs: What Do We Know?* Working Paper No. 169 (Chicago, Ill.: Joint Center for Poverty Research, April 2000).

34. General Accounting Office, *Head Start: Research Provides Little Information on Impact of Current Program*, GAO/HEHS-97-59 (April 1997), p. 2.

Expanding Head Start. Various proposals have been made to increase federal support for preschool education. Some options would make services like those provided in Head Start available to more 3- and 4-year-olds. Other options would increase the services provided to children already enrolled, including expanding the length of the program from half-day to full-day, or focus funding on programs that provide services to parents and to children at younger ages.

A specific proposal would be to increase Head Start funding sufficiently to enroll all 3- and 4-year-olds from low-income families. In 1999, more than 30 percent of eligible 3-year-olds and about 60 percent of eligible 4-year-olds were enrolled in the program. Enrolling all children from families with income below the federal poverty threshold today could raise the program's annual price tag from about $6.2 billion to about $10.6 billion if the average federal service grant per Head Start enrollee remained unchanged. Also, because federal funds cover only 80 percent of Head Start's costs, expansion would be limited if states were not able to finance their 20 percent of the cost. In that case, the federal costs would be even higher.

The federal costs also could be higher than $10.6 billion per year for other reasons. First, although the existing programs often make use of underutilized facilities and volunteer staff to reduce costs, significant further expansions of the program would be likely to exhaust those opportunities. Providing more classrooms and training more teachers to meet the program's expanded requirements would demand additional resources. Second, a larger program would need to attract new teachers away from other jobs and career paths by offering them higher salaries. To prevent dissatisfaction and turnover among current teachers, their salaries would probably have to be raised as well. Third, for the positive effects of the model preschool programs to carry over to Head Start, many Head Start teachers would probably need increased training, and the program would have to provide an expanded array of services to participants and their families.

Achieving 100 percent enrollment of 3- and 4-year-olds from low-income families would be very unlikely, however—thus reducing the cost of the option. Many parents prefer home-based care, regard-

less of the availability and cost of center-based care. And the half-day schedule of most Head Start centers conflicts with the schedules of some working parents. It might be difficult for those parents to find adequate child care for the remaining part of the day and arrange for the transfer of their children from one place to another. Finally, the location of some Head Start centers makes them inconvenient for some families with limited transportation options.

Improving Elementary and Secondary Education

The federal government will provide approximately $27 billion in aid to elementary and secondary schools in the 2001-2002 academic year to fund a range of activities. Some aid supports improved education for children who are poor or have disabilities; other aid finances education reform and school improvement initiatives.

The government's first major effort to aid public elementary and secondary education (the Title I program) began in the mid-1960s as part of the war on poverty. Experience since then has shown that increasing the quality of schools that poor children attend can go only a small way toward closing the gap between their academic achievement and that of their higher-income peers. Other factors, such as difficult home situations and detrimental neighborhood influences, can undermine the efforts of schools to increase achievement but are much more difficult to address through federal policies. Federal spending on disadvantaged children through state grants for Title I totals $9.4 billion in 2001, or about one-third of all federal spending on elementary and secondary education.

In 1975, the Individuals with Disabilities Education Act became law, requiring states and school districts to provide a free, appropriate public education to children with disabilities. Doing so is very expensive. By some estimates, the cost of educating a disabled child is two to two-and-a-half times the cost of educating a nondisabled child, although that figure probably varies widely among states and school districts.[35] In passing that act, the Congress authorized a federal contribution for each disabled child served of up to 40 percent of the national average per-pupil expenditure for all students. At about $6.3 billion, however, current federal funding gives states only about 15 percent of the national average per-pupil expenditure. Providing states with the 40 percent amount would require an additional $10.4 billion a year, assuming that the number of children identified as disabled remained unchanged.

Since the early 1990s, federal education policies have focused on a very different way of improving education outcomes. Along with continuing to aid special populations of students, those policies have encouraged broad-based education reform and improvement in schools.

Proposals to increase the effectiveness of U.S. schools range from state-level, top-down strategies to grass-roots strategies that address local problems. An example of a top-down strategy is one that would require states receiving federal funds to develop standards for what children should know in various grades and help states develop assessments of students' performance in various subject areas. An example of a grass-roots strategy is one that would support local groups that want to start charter schools, which implement specific education strategies appropriate to local needs.

Other recent proposals would strive to improve schools by expanding or improving the inputs into the education process. Some proposals would support the professional development of teachers in areas such as science and math or would improve the quality of teachers by funding mentoring programs that team experienced teachers with inexperienced ones. Other proposals would support state and local efforts to improve school facilities, including constructing and renovating school buildings and bringing Internet access to classrooms.

The quantity and quality of teachers are critical determinants of a school's success. Public elementary and secondary schools today employ over 2.9

35. M.T. Moore and others, *Patterns in Special Education Service Delivery and Cost* (Washington, D.C.: Decision Resources Corporation, 1988).

million teachers. More than half of them have a master's degree, and the median teacher has more than 15 years of teaching experience. Their average salary is an estimated $44,000 for the school year, and the starting salary is about $30,000.

Increasing the number of teachers in the early grades, thereby reducing class size, could be one way to improve education outcomes. Kindergarten classes have 20 children on average, and averages for the early elementary grades are somewhat larger. The Congress appropriated $1.6 billion for academic year 2001-2002 to help reduce class size to 18 students per teacher in grades K through 3, and proposals have been made to continue and increase that amount.

Perhaps the best research evidence on the effectiveness of smaller classes on students' achievement is Tennessee's STAR project.[36] Children entering kindergarten were randomly assigned to small classes of 13 to 17 students and regular classes of 22 to 26 students. Through third grade, students in small classes outperformed those in regular classes on both standardized and curriculum-based tests. (For minority students, the positive effect was twice that for nonminority students.) Beginning in fourth grade, all students went to regular classes. At least through eighth grade, a decreasing but still significantly higher level of achievement persisted for students who had been in the small classes.

One critique of those generally positive results is that the gains from being in a small class did not accumulate over time. If education is cumulative, with each year building on what was learned in the previous years, then children assigned to small classes would be expected to pull farther away each year from their counterparts in larger classes. In fact, the evidence shows such advances only in the first year and, to some extent, the second. After that, while the performance of students in small classes exceeded that of students in larger classes, there was no additional gain from being in a small class.

Reducing class size in kindergarten through third grade by five students per class would require hiring approximately 250,000 additional teachers. Paying those additional teachers at current beginning compensation levels would cost about $10 billion per year.

The salaries of both current and new teachers would probably have to be raised to meet the extra demand, however. Those higher salaries could add another $4 billion to $8 billion annually to the price of this option, under the assumption that salaries of all elementary teachers rose by 5 percent to 10 percent. Additional costs would be incurred to recruit and train teachers, to give salary increases in future years, and to build the added classrooms that would be needed to accommodate the larger number of classes.

Hiring a large number of new teachers quickly could also require hiring some underqualified ones —ones who did not meet the usual state standards. This problem has occurred recently in California, as that state implemented its own program to reduce class size. Underqualified teachers could be given a limited time to increase their qualifications to acceptable levels, but that added demand could overuse and dilute the quality of teacher-education resources. Some or all of the value of the smaller classes could be lost if the teachers in those classes were underqualified.

The task of reducing class size would be made even harder by the impending retirement of a large share of current teachers. Nearly 50 percent of elementary and secondary school teachers today—about 1.4 million teachers—are age 45 or older. Finding replacements for those experienced teachers when they retire would add considerably to the difficulty of expanding the overall number of teachers.

Promoting Greater Investment in Higher Education

Enrollment rates in postsecondary schools have increased in recent years, as have the monetary returns from a college education. However, the cost of postsecondary education has also grown, having outpaced

36. E. Ward and others, *Student/Teacher Achievement Ratio (STAR): Tennessee's K-3 Class-Size Study* (Nashville, Tenn.: Tennessee State Department of Education, 1990).

the growth in family income for more than two decades.

The federal government has long promoted attendance at colleges and trade schools. Currently, about 80 percent of students from upper-income families enroll in college or trade school immediately after high school graduation. In contrast, fewer than 50 percent of students from low-income families enroll, even with the availability of significant amounts of federal and other aid. Perhaps the most important goals of federal policies for higher education are to remove the financial barriers to attendance faced by low-income students and to keep college affordable for middle-income families.

To help achieve those goals, the Congress created several programs, including a federal student loan program in 1959, the Pell Grant program in 1972, and tax credits for postsecondary education in 1997. Last year, the student loan program provided $33 billion in loans to about 5.5 million students and their parents at a federal cost of approximately $5.0 billion. The Pell Grant program provided more than $7.0 billion in aid to nearly 4 million students with very low income. And for the 1999 tax year, more than 10 million filers received an estimated $5.2 billion in education tax credits and deductions for interest on student loans.

In recent years, the Congress has increased federal student aid in several ways:

- By reducing the interest rate on nearly all federal student loans by 0.8 percentage points in 1998 through 2003;
- By increasing the maximum Pell grant incrementally from $2,900 for academic year 1997-1998 to $3,750 for 2001-2002;
- By creating tax credits of up to $1,500 for tuition expenses and tax deductions for interest expenses on student loans; and
- By making earnings on contributions to education savings accounts and state prepaid tuition plans tax free or tax deferred.

The Effectiveness of Student Aid in Increasing College Attendance. The availability of student financial aid—from the original GI bill to the more recent federal grant and loan programs—has allowed many students to attend college or trade school who otherwise would not have, and others to pursue their postsecondary education further. On the basis of recent studies of students' experiences in the 1980s and Georgia's HOPE Scholarship program in the 1990s, a $1,000 increase in grant aid to all high school graduates would increase the proportion attending college or trade school by 4 percentage points.[37] Similarly, based on another study, a $1,000 reduction in tuition at public two-year colleges is associated with a 7 percentage-point increase in enrollment rates among 18- and 19-year-olds.[38] There was no disproportional growth in enrollment by low-income youth relative to high-income youth, however, after the Pell Grant program was established in the mid-1970s. It appears that young people are sensitive to the cost of continuing their education beyond high school but that problems in understanding and applying for financial aid may deter college attendance, particularly among youth whose parents did not attend college.

Although the size of the effect is difficult to estimate, federal aid does induce some students, particularly those from low-income families, who would not have attended college or trade school to enroll in postsecondary education. It also increases the length of time some lower-income students remain in school. However, the aid also subsidizes many students who would have attended school without it.

Increasing Pell Grants. One option to promote greater investment in postsecondary education would target additional aid toward students with low income by expanding the maximum award in the Pell Grant program. That award could be increased from its current appropriated level of $3,750 to the full autho-

37. Susan M. Dynarski, *Does Aid Matter? Measuring the Effect of Student Aid on College Attendance and Completion*, Working Paper No. 7422 (Cambridge, Mass.: National Bureau of Economic Research, November 1999), and Dynarski, *Hope for Whom? Financial Aid for the Middle Class and Its Impact on College Attendance*, Working Paper No. 7756 (Cambridge, Mass.: National Bureau of Economic Research, June 2000).

38. Thomas J. Kane, *Rising Public College Tuition and College Entry: How Well Do Public Subsidies Promote Access to College*? Working Paper No. 5164 (Cambridge, Mass.: National Bureau of Economic Research, July 1995).

rized limit of $5,400 in 2002. Doing so would raise the cost of the Pell Grant program from $9.3 billion to about $15.7 billion.

Most of the added funding would go to the estimated 4 million current Pell grant recipients, whose average award would increase from $2,330 to nearly $3,600. The higher limit would also raise the number of students who were eligible for Pell grants, adding about 600,000 new recipients to the program.[39] Finally, raising the maximum Pell grant would induce some young people to enroll who previously found college or trade school too expensive. An estimated 300,000 new students would be added in that way.

In addition, the more generous aid would increase the number of affordable choices available to some young people already attending school. Some students might transfer from a two-year college near their home to a state four-year college farther away. Others might give up jobs to focus entirely on school.

Several other considerations would affect the desirability of increasing the federal grant. Pell grants are available to any low-income student who has graduated from high school or passed the General Education Development tests. Many students who enroll in college drop out before graduating, in part because some of them are probably not adequately prepared. Increasing the amount of financial aid that is available might be more effective if steps were also taken to better prepare students.

One way to motivate students to prepare for college is to make them aware of available aid early in their school career. Some analysts believe that middle-school students are generally unaware of the amount of federal aid that is available to them and might therefore underestimate their ability to go to college. Programs to make all seventh- or eighth-grade students more aware of college aid might improve their preparedness for, and enrollment in, college.

A final consideration is that a large part of the gain from higher education today is a private benefit. College graduates with a bachelor's degree earn substantially more than people with only a high school diploma. Furthermore, attending college enriches students' lives in other ways that are long lasting and extend to their children. Because students enjoy most of the benefits, one can argue that they should bear most of the cost. Accordingly, the role of federal policy might be to ensure that students who want to attend school are not prevented from doing so by temporary financial constraints; that could be achieved by increasing the availability of education loans. Although financing their education with loans increases the amount of debt the students amass by the time they leave school, federal policies already exist to provide borrowers with options for repaying loans that make the burden more manageable. For example, borrowers may extend the repayment period beyond the usual 10 years or choose graduated payments that rise over time with expected increases in income.

39. A student is eligible to receive a Pell grant equal to the appropriated maximum less the student's and his or her family's expected contribution, which is based on family income and the number of siblings in college at the same time, but no more than the difference between the cost of education and the expected family contribution. Consequently, as the appropriated maximum increases, more students become eligible for grants who previously had an expected contribution near or above that maximum.